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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **EVERETT JOHN EQUILA** **2013 N. Edison Blvd.** **Burbank, CA 91505** **Registered Nurse License No. 546761** Respondent.	Case No. 2010-155 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 12, 1998, the Board issued Registered Nurse License Number 546761 to Everett John Equila ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2011, unless renewed.

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STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
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> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Health and Safety Code section 11173, subdivision (a), states, in pertinent part, that "[n]o person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . ."

8. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCE AT ISSUE

10. "Dilaudid", a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

FIRST CAUSE FOR DISCIPLINE

(Diversion of Controlled Substances)

11. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that in and between June and August 2005, while employed or on duty as a registered nurse in the Pediatric Intensive Care Unit at Cedars Sinai Medical Center, Los Angeles, California, Respondent obtained the controlled substance Dilaudid by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: During the time period indicated above, Respondent removed a number of hydromorphone 2 mg injectables and Dilaudid PCA (patient controlled analgesia)

30 mg/30 ml units from the storage area of the hospital, then altered the Controlled Medication Disposition Records ("CMDR") by overwriting prior entries on the CMDR to reflect a lower number or quantity of Dilaudid in the hospital's inventory than was originally documented, as more particularly set forth in paragraph 12 below.

SECOND CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

12. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that in and between June and August 2005, while employed or on duty as a registered nurse in the Pediatric Intensive Care Unit at Cedars Sinai Medical Center, Los Angeles, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substance Dilaudid, as follows:

a. On June 8, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 24 to 21, leaving three 2 mg units of hydromorphone unaccounted for.

b. On June 8, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of Dilaudid PCA 30 mg/30 ml units in the hospital's inventory from 2 to 1, leaving one 30 mg/30 ml unit of Dilaudid PCA unaccounted for.

c. On June 10, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 14 to 10, leaving four 2 mg units of hydromorphone unaccounted for.

d. On June 10, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of Dilaudid PCA 30 mg/30 ml units in the hospital's inventory from 1 to 0, leaving one 30 mg/30 ml unit of Dilaudid PCA unaccounted for.

e. On June 13, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 14 to 10, leaving four 2 mg units of hydromorphone unaccounted for.

f. On June 15, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 10 to 6, leaving four 2 mg units of hydromorphone unaccounted for.

g. On June 16, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 6 to 4, leaving two 2 mg units of hydromorphone unaccounted for.

h. On June 17, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 4 to 2, leaving two 2 mg units of hydromorphone unaccounted for.

i. On June 18, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 2 to 1, leaving one 2 mg unit of hydromorphone unaccounted for.

j. On June 21, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 4 to 2, leaving two 2 mg units of hydromorphone unaccounted for.

k. On June 23, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 20 to 18, leaving four 2 mg units of hydromorphone unaccounted for.

l. On July 1, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of Dilaudid PCA units in the hospital's inventory from 2 to 1, leaving one unit of Dilaudid PCA unaccounted for.

m. On July 2, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 14 to 12, leaving two 2 mg units of hydromorphone unaccounted for.

n. On July 7, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 22 to 20, leaving four 2 mg units of hydromorphone unaccounted for.

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o. On July 8, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 20 to 16, leaving four 2 mg units of hydromorphone unaccounted for.

p. On July 9, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 16 to 14, leaving two 2 mg units of hydromorphone unaccounted for.

q. On July 13, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 11 to 7, leaving four 2 mg units of hydromorphone unaccounted for.

r. On July 13, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of Dilaudid PCA 30 mg/30 ml units in the hospital's inventory from 2 to 1, leaving one 30 mg/30 ml unit of Dilaudid PCA unaccounted for.

s. On July 16, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 23 to 20, leaving three 2 mg units of hydromorphone unaccounted for.

t. On July 28, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 19 to 14, leaving five 2 mg units of hydromorphone unaccounted for.

u. On July 29, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 11 to 9, leaving two 2 mg units of hydromorphone unaccounted for.

v. On July 30, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 3 to 0, leaving three 2 mg units of hydromorphone unaccounted for.

w. On July 30, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of Dilaudid PCA 30 mg/30 ml units in the hospital's inventory from 2 to 1, leaving one 30 mg/30 ml unit of Dilaudid PCA unaccounted for.

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x. On August 4, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 9 to 6, leaving three 2 mg units of hydromorphone unaccounted for.

y. On August 4, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of Dilaudid PCA 30 mg/30 ml units in the hospital's inventory from 1 to 0, leaving one 30 mg/30 ml unit of Dilaudid PCA unaccounted for.

z. On August 5, 2005, Respondent altered the existing entry on the CMDR and overwrote or changed the number of hydromorphone 2 mg injectables in the hospital's inventory from 7 to 5, leaving two 2 mg units of hydromorphone unaccounted for.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that in and between June and August 2005, while employed or on duty as a registered nurse in the Pediatric Intensive Care Unit at Cedars Sinai Medical Center, Los Angeles, California, Respondent was guilty of gross negligence within the meaning of Regulation 1442, as set forth in paragraphs 11 and 12 above.

FOURTH CAUSE FOR DISCIPLINE

(Use of Dangerous Drugs)

14. Respondent is subject to disciplinary action pursuant to Code section 2762, subdivision (b), on the grounds of unprofessional conduct, in that between June and August 2005, while employed or on duty as a registered nurse in the Pediatric Intensive Care Unit at Cedars Sinai Medical Center, Los Angeles, California, Respondent used dangerous drugs in a manner that was dangerous or injurious to himself, any other person, or the public or to the extent that such use impaired his ability to conduct with safety to the public the practice authorized by his license as set forth in paragraphs 11 and 12 above.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 546761, issued to Everett John Equila;

2. Ordering Everett John Equila to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/15/09

Louise R. Bailey

LOUISE R. BAILEY, M.Ed, RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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